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*An Experimental Study of the Physiological Accompaniments of Feeling.*—L. P. BOGGS, *Psychological Review*, Vol. XI, Nos. 4-5, pp. 223-248.

This is the result of studies made for the purpose of testing Dr. Max Brahn's tridimensional theory of feeling. Marey's sphygmograph and the pneumograph were used. The writer concludes as follows: Strain is accompanied by a decrease in the length of the pulse curve, while the dicrotic wave becomes lower. Relaxation is accompanied by an increase in the pulse length and a heightened dicrotic wave. The state of attention is accompanied by a feeling of concentration, partaking of the nature of strain, and has parallel physiological processes resembling those of strain and relaxation, but the characteristics are less marked. The breathing in both the feeling of strain and relaxation is more rapid, regular and shallow than in an indifferent state. Pleasantness is accompanied by a larger and higher pulse curve; unpleasantness by the reverse. Excitement and repose are accompanied by less marked changes in the vaso-motor system than the other feelings and with practically no change in the pulse frequency. The excitement-strain feeling shows characteristics of the curves of both, while the excitement-pleasure feeling is pretty constant in showing a lengthened and heightened curve. The curves for excitement-unpleasantness have no constant characteristics. Repose-unpleasantness is accompanied by no constant marked characteristics, but unpleasantness-repose is accompanied usually by a shorter and decidedly lower pulse curve. When the feelings are mixed, pleasantness and unpleasantness do not appear until after those of excitement and repose. The time of the appearance of the feeling of strain depends on the time it takes for the concentration of the attention to the stimulus. Sometimes it appears almost at once, and again two or three pulses later. When it appears in a mixed feeling, it comes later than in the others. The rhythm in the pulse lengths which correspond roughly to the act of breathing, tends to disappear during states of attention and the more so the stronger the feeling of strain and relaxation or of concentration. [Work much along the same lines has been conducted by Sommer (Beiträge zur psychiatrischen Klinik. Bd. I. H. 3. Nov. 3, 1902) on the measurements of the motor accompaniments of psychical states and by N. Hirschberg (Ueber die Beziehungen psychischen Zustände zum Kreislauf und zur Athmung, St. Petersburg Med. Woch., 1903., No. 2). The latter, as the result of elaborate experiments on normal individuals and in those suffering with mental disease, found that every mental state, whether normal or abnormal, was associated with characteristic changes in the pulse and respiration.]

*Lectures on Clinical Psychiatry.* EMIL KRAEPELIN. Translated by Thomas Johnstone. London, Baillière, Tindall and Cox. 1904.

This is a translation of the Einführung in die Psychiatrische Klinik, and it forms an excellent clinical companion to the Lehrbuch. Certainly, for the novice, who wishes to obtain an insight into clinical psychiatry, it is to be preferred to the larger text book. The work comprises in all thirty lectures, and includes all the forms of mental disease. The cases selected for demonstration and discussion are not of a very complex type, in order to more clearly elucidate the peculiar symptomatology and differential diagnosis of each form of mental disease.

*Das Delirium Alcoholicum Febrile Magnan's.* DR. ALZHEIMER. Centralblatt für Nervenheilkunde, Bd. XXVII, No. 174, July, 1904.

Alzheimer has observed three cases among 160 of alcoholic delirium.

All were schuapps drinkers and the mental symptoms followed an early and serious epileptiform attack, the temperature rising to 41.8° C. and death supervened in several hours. The clinical picture was that of a severe delirium with marked motor restlessness, clonic spasms of the limbs, ataxia, paraphasic speech disturbances, heart weakness and cyanosis. At autopsy there was found cirrhosis of the liver, fatty degeneration of the kidneys, degeneration of the Betz and Purkinje cells, slight neuroglia proliferation, small cortical hemorrhage and grave alterations of the capillaries, but no traces of any inflammatory process.

*Un Cas D'Amnesie Continue Avec Asymbolie Tactile, Complicue D'Autres Troubles.* B. BOURDON and M. DIDE. *L'Année Psychologique*, 1904. pp. 84-115.

The authors relate a very valuable and interesting case of tactile asymbolia, and it may be well in this connection to call attention to Liepmann's famous case of one-sided apraxia (motor asymbolia), since it has lately come to autopsy. (Das Krankheitsbild der Apraxie motorischen Asymbolie, auf Grund eines Falles von einseitiger Apraxie. *Monat. f. Psychiatrie und Neurologie*. Bd. VIII. H 1, 2, 3, 1900.) Bourdon and Dides's patient was a man 54 years of age, with a negative family history, married, and the father of three healthy children. He never had any serious illness; had received a fair education and was able to read and write. Four months after entering the hospital at Fougères, he had an episode in which he became violently agitated and was transferred to the Asylum at Rennes on April 19, 1902. Without any shock that could be observed, there suddenly occurred on May 3, of the same year, complete word blindness without mind blindness. He recognized and correctly named objects which were shown him, there was no word deafness or agraphia, he was able to write his name spontaneously and could write correctly from dictation, but copying was impossible. He also showed a tactile asymbolia (loss of the faculty of recognizing objects by touch) and a moderate degree of astereognosis (loss of the faculty to recognize the shape of objects by touch). On Sept. 9, 1902, there was a slight shock, the patient became confused and showed nearly complete word deafness. This symptom diminished, but on Oct. 16, there supervened another agitated episode, he pronounced disconnected words and threw objects about the ward. From this he went into a state of religious exaltation, in which he kneeled and prayed a great deal and pronounced phrases devoid of sense. Once he said, "I am not an idiot, do not try to mix me up." On March 10, 1903, there was another slight shock, the mouth was turned slightly to the left, the eyes to the right and the cheeks were flaccid. He lay in a stupor, completely unconscious, the legs were drawn up and the reflexes exaggerated. He improved rapidly within the next few days and recognized and correctly named his relatives when visited by them.

#### ANALYSIS OF THE CASE.

An examination of the eyes showed the fundus to be pale, there was a narrowing of the visual field and probable diplopia, but no dyschromatopsia. Hearing was not impaired. Taste was good, but he was unable to name the solutions. Smell was fair, and although he could not name all the odors, yet he reacted well to disagreeable ones. The pressure sense was diminished, the temperature, pain and weight sense were normal. In tests for the tactile sense, the results were confusing. The muscular sense of position was intact. In testing the *stereognostic sense*, it was found that he did not know simple objects, but at times could recognize them, better by sight and touch associa-